Schedule 13
Change Request for FY 08-09 Budget Request Cycle

	Decision Item FY 08-09 ☐	**Base Reduction Item FY 08-09** ☐	**Supplemental FY 07-08** ☐	**Budget Request Amendment FY 08-09** ☑
Request Title:	Efficiencies in Medicaid Cost Avoidances and Provider Recoveries			
Department:	Health Care Policy and Financing	**Dept. Approval by:** John Bartholomew	**Date:**	January 23, 2008
Priority Number:	BA - 9	**OSPB Approval:**	**Date:**	

		1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual	Appropriation	Supplemental Request	Total Revised Request	Base Request	Decision/ Base Reduction	November 1 Request	Budget Amendment	Total Revised Request	Change from Base (Column 5)
	Fund	FY 06-07	FY 07-08	FY 07-08	FY 07-08	FY 08-09	FY 08-09	FY 08-09	FY 08-09	FY 08-09	FY 09-10
Total of All Line Items											
	Total	2,105,110,552	2,189,454,599	0	2,189,454,599	2,192,017,136	0	2,192,017,136	(2,100,762)	2,189,916,374	(5,360,226)
	FTE	225.36	245.30	0	245.30	259.50	0	259.50	5.50	265.00	6.00
	GF	646,774,200	666,107,835	0	666,107,835	665,735,833	0	665,735,833	(1,462,981)	664,272,852	(2,742,612)
	GFE	343,100,000	343,900,000	0	343,900,000	343,900,000	0	343,900,000	0	343,900,000	0
	CF	62,998	639,041	0	639,041	1,635,410	0	1,635,410	0	1,635,410	0
	CFE	49,866,112	77,328,124	0	77,328,124	79,575,519	0	79,575,519	0	79,575,519	0
	FF	1,065,307,242	1,101,479,599	0	1,101,479,599	1,101,170,374	0	1,101,170,374	(637,781)	1,100,532,593	(2,617,614)
(1) Executive Director's Office Personal Services											
	Total	15,260,951	16,715,590	0	16,715,590	18,860,743	0	18,860,743	377,611	19,238,354	414,476
	FTE	225.36	245.30	0.00	245.30	259.50	0.00	259.50	5.50	265.00	6.00
	GF	6,054,845	7,261,822	0	7,261,822	7,768,653	0	7,768,653	188,805	7,957,458	207,238
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	140,495	0	140,495	212,681	0	212,681	0	212,681	0
	CFE	399,006	592,486	0	592,486	2,121,195	0	2,121,195	0	2,121,195	0
	FF	8,807,100	8,720,787	0	8,720,787	8,758,214	0	8,758,214	188,806	8,947,020	207,238
(1) Executive Director's Office SB 04-257 Amortization Equalization Disbursement											
	Total	93,197	178,339	0	178,339	243,206	0	243,206	5,413	248,619	5,906
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	41,256	76,448	0	76,448	108,110	0	108,110	2,706	110,816	2,953
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	2,092	5,855	0	5,855	12,070	0	12,070	0	12,070	0
	FF	49,849	96,036	0	96,036	123,026	0	123,026	2,707	125,733	2,953

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	Decision Item FY 08-09 ☐	**Base Reduction Item FY 08-09** ☐	**Supplemental FY 07-08** ☐	**Budget Request Amendment FY 08-09** ☑
Request Title:	Efficiencies in Medicaid Cost Avoidances and Provider Recoveries			
Department:	Health Care Policy and Financing	**Dept. Approval by:** John Bartholomew	**Date:**	January 23, 2008
Priority Number:	BA - 9	**OSPB Approval:**	**Date:**	

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 06-07	Appropriation FY 07-08	Supplemental Request FY 07-08	Total Revised Request FY 07-08	Base Request FY 08-09	Decision/ Base Reduction FY 08-09	November 1 Request FY 08-09	Budget Amendment FY 08-09	Total Revised Request FY 08-09	Change from Base (Column 5) FY 09-10
(1) Executive Director's Office Supplemental Amortization Equalization Disbursement (SB 06-235)	**Total**	0	34,950	0	34,950	77,872	0	77,872	2,538	80,410	1,846
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	13,722	0	13,722	34,615	0	34,615	1,269	35,884	923
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	1,220	0	1,220	3,866	0	3,866	0	3,866	0
	FF	0	20,008	0	20,008	39,391	0	39,391	1,269	40,660	923
(1) Executive Director's Office Operating Expenses	**Total**	1,196,014	1,039,465	0	1,039,465	1,023,940	0	1,023,940	59,230	1,083,170	38,500
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	586,457	494,229	0	494,229	486,342	0	486,342	29,615	515,957	19,250
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	14,395	0	14,395	3,800	0	3,800	0	3,800	0
	CFE	8,151	14,546	0	14,546	27,093	0	27,093	0	27,093	0
	FF	601,406	516,295	0	516,295	506,705	0	506,705	29,615	536,320	19,250
(1) Executive Director's Office Legal Services and Third Party Recovery Legal Services	**Total**	763,821	913,629	0	913,629	913,629	0	913,629	19,415	933,044	19,415
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	318,913	370,501	0	370,501	370,501	0	370,501	9,708	380,209	9,708
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	62,998	76,924	0	76,924	76,924	0	76,924	0	76,924	0
	CFE	0	6,319	0	6,319	6,319	0	6,319	0	6,319	0
	FF	381,910	459,885	0	459,885	459,885	0	459,885	9,707	469,592	9,707

Schedule 13
Change Request for FY 08-09 Budget Request Cycle

	Decision Item FY 08-09 ☐	**Base Reduction Item FY 08-09** ☐	**Supplemental FY 07-08** ☐	**Budget Request Amendment FY 08-09** ☑
Request Title:	Efficiencies in Medicaid Cost Avoidances and Provider Recoveries			
Department:	Health Care Policy and Financing	**Dept. Approval by:** John Bartholomew	**Date:**	January 23, 2008
Priority Number:	BA - 9	**OSPB Approval:**	**Date:**	

		1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual	Appropriation	Supplemental Request	Total Revised Request	Base Request	Decision/ Base Reduction	November 1 Request	Budget Amendment	Total Revised Request	Change from Base (Column 5)
	Fund	FY 06-07	FY 07-08	FY 07-08	FY 07-08	FY 08-09	FY 08-09	FY 08-09	FY 08-09	FY 08-09	FY 09-10
(1) Executive Director's Office Administrative Law Judge Services	Total	380,930	407,509	0	407,509	453,207	0	453,207	9,631	462,838	9,631
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	190,465	203,755	0	203,755	226,604	0	226,604	4,816	231,420	4,816
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	190,465	203,754	0	203,754	226,603	0	226,603	4,815	231,418	4,815
(1) Executive Director's Office Medicaid Management Information System Contract	Total	26,018,831	22,306,209	0	22,306,209	22,817,549	0	22,817,549	50,400	22,867,949	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	6,204,550	5,265,858	0	5,265,858	5,228,266	0	5,228,266	12,600	5,240,866	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	368,971	0	368,971	1,303,749	0	1,303,749	0	1,303,749	0
	CFE	596,657	706,330	0	706,330	610,809	0	610,809	0	610,809	0
	FF	19,217,624	15,965,050	0	15,965,050	15,674,725	0	15,674,725	37,800	15,712,525	0
(1) Executive Director's Office Enhanced Fraud Detection Contracting (new line item)	Total	0	0	0	0	0	0	0	1,250,000	1,250,000	500,000
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	225,000	225,000	187,500
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	1,025,000	1,025,000	312,500

Schedule 13
Change Request for FY 08-09 Budget Request Cycle

	Decision Item FY 08-09 ☐			**Base Reduction Item FY 08-09** ☐			**Supplemental FY 07-08** ☐		**Budget Request Amendment FY 08-09** ☑		
Request Title:	Efficiencies in Medicaid Cost Avoidances and Provider Recoveries										
Department:	Health Care Policy and Financing			**Dept. Approval by:** John Bartholomew				**Date:**	January 23, 2008		
Priority Number:	BA - 9			**OSPB Approval:**				**Date:**			
		1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual	Appropriation	Supplemental Request	Total Revised Request	Base Request	Decision/ Base Reduction	November 1 Request	Budget Amendment	Total Revised Request	Change from Base (Column 5)
	Fund	FY 06-07	FY 07-08	FY 07-08	FY 07-08	FY 08-09	FY 08-09	FY 08-09	FY 08-09	FY 08-09	FY 09-10
(2) Medical Services Premiums	Total	2,061,396,808	2,147,858,908	0	2,147,858,908	2,147,626,990	0	2,147,626,990	(3,875,000)	2,143,751,990	(6,350,000)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	633,377,714	652,421,500	0	652,421,500	651,512,742	0	651,512,742	(1,937,500)	649,575,242	(3,175,000)
	GFE	343,100,000	343,900,000	0	343,900,000	343,900,000	0	343,900,000	0	343,900,000	0
	CF	0	38,256	0	38,256	38,256	0	38,256	0	38,256	0
	CFE	48,860,206	76,001,368	0	76,001,368	76,794,167	0	76,794,167	0	76,794,167	0
	FF	1,036,058,888	1,075,497,784	0	1,075,497,784	1,075,381,825	0	1,075,381,825	(1,937,500)	1,073,444,325	(3,175,000)

Letternote revised text:	
Cash Fund name/number, Federal Fund Grant name:	FF: Title XIX
IT Request: ☐ Yes ☑ No	
Request Affects Other Departments: ☐ Yes ☑ No	**If Yes, List Other Departments Here:**

CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	BA - 9
Change Request Title:	Efficiencies in Medicaid Cost Avoidances and Provider Recoveries

SELECT ONE (click on box):

☐ Decision Item FY 08-09
☐ Base Reduction Item FY 08-09
☐ Supplemental Request FY 07-08
☒ Budget Request Amendment FY 08-09

SELECT ONE (click on box):

Supplemental or Budget Request Amendment Criterion:
☐ Not a Supplemental or Budget Request Amendment
☐ An emergency
☐ A technical error which has a substantial effect on the operation of the program
☒ New data resulting in substantial changes in funding needs
☐ Unforeseen contingency such as a significant workload change

Short Summary of Request: This request is for 5.5 FTE annualizing to 6.0 FTE and a net reduction in funding of $2,100,762 in FY 08-09. The Department is seeking funding to strengthen the Medicaid provider re-enrollment process and implement enhanced fraud detection technology. These improvements are expected to reduce the amount of fraudulent and erroneous Medicaid payments.

Background and Appropriation History: The Department's Program Integrity section monitors and improves provider accountability for the Medicaid program. Program Integrity staff identify potentially excessive or improper utilization, or improper billing of the Medicaid program by providers. If a situation is identified, staff follow-up to investigate, classify, and recover payments and/or refer the providers to legal authorities for possible prosecution when appropriate. Providers are currently selected for review in one of three ways. The first way is when the section receives complaints or referrals questioning improper or incorrect payments, and a preliminary investigation is conducted. If it is deemed necessary based on this preliminary review, a case is opened to perform a full

investigation of the provider. The second way of identifying a provider for review is through review of comparison reports of like providers – if a particular provider is not similar to those in the same group, the Department opens a case for review. Finally, the third way providers are selected for review is by developing a study by which payments to all providers in the same category of service will be examined under the criteria developed for the study. Interventions for improper use of the Medicaid program can range from education and recovery of overpayments, to restriction or exclusion from participation in the program. Civil and criminal sanctions may also be pursued by the Department and the Medicaid Fraud Control Unit.

As of August 2007 Colorado contracted with over 50,000 healthcare providers who are actively engaged in the delivery of healthcare related goods and services to low-income Coloradans enrolled in the state's Medicaid program.[1] More than 54 types of providers contract with the state including doctors, dentists, chiropractors, hospitals, laboratories, pharmacies, durable medical equipment, and emergency and non-emergency transportation providers.

General Description of Request: This request is for total funds of $1,774,238 and an additional 5.5 FTE in FY 08-09 (6.0 FTE annualized beginning in FY 09-10) to implement improvements to the Medicaid provider re-enrollment process as well as purchase enhanced fraud detection technology. These improvements are expected to result in savings of $3,875,000 total funds in FY 08-09, resulting in a net decrease in funding of $2,100,762.

Strengthening Provider Enrollment

The Department of Health Care Policy and Financing does not currently require Medicaid providers to re-apply once their application for participation has been approved. Once a provider has been approved, they remain enrolled in the program indefinitely, although they are required to update affiliations, logistics, disclosures of

[1] Colorado Department of Health Care Policy and Financing, COLD MARS Report #M222200 – Provider Participation Analysis For the Period of 05/01/2007 through 05/31/2007.

convictions and ownership (if they own 5% or more of an entity) by either letter or fax to Affiliated Computer Systems, the State's contracted fiscal agent.

Approval involves a desk review by Affiliated Computer Systems of the providers' applications without on-site inspection or investigation because Colorado currently has no field staff to perform such reviews. Affiliated Computer Systems checks a List of Excluded Individuals and Entities (LEIE) – exclusions from any federal program – to see if a provider has been excluded or debarred in another state. The Department's Program Integrity section has acquired a comprehensive provider database from the Centers for Medicare and Medicaid Services. The Department is in the process of cross referencing this database against the State's current list of providers to see if any exclusions have been missed by Affiliated Computer Systems' process and database.

Colorado law cites conviction for fraud or another felony as good causes for the Medicaid program exclusion. During the prior Governor's term, few providers were removed from the program as a result of such convictions. However, over-billing and other program abuse is not considered "good cause" for termination unless the Department's Program Integrity section can document a "pattern of abuse." Currently, approximately one provider per year is removed from the program for this reason.

In 2004 the U.S. Office of Inspector General published a report listing the approaches used by the states to maintain a qualified pool of providers and limit Medicaid fraud. States' approaches for keeping 'bad actors' out of the Medicaid program included:

- Measures applied to all providers
  - Review and update provider enrollment information
  - Time-limited enrollment
  - Cancellation or suspension of inactive billing numbers

- Measures applied to high-risk providers
  - Surety bonds
  - On-site inspections

- Criminal background checks
- Intensified claims review and auditing
- Targeted provider education
- Time limited enrollment

California experienced over $200 million in cost avoidance for the state and federal government in one year after implementing measures to more closely scrutinize provider enrollment applications.[2]

Colorado currently employs only three of these techniques: cancellation of inactive billing numbers, intensified claims review, and targeted provider education of high risk providers. At one time about four years ago, Colorado employed a fourth technique by un-enrolling one of its Medicaid transportation providers and requiring them to reapply.

The Department's plan to strengthen provider enrollment includes the following:

- Requiring more frequent re-enrollment of providers deemed as high-risk by the Department's Program Integrity section. Working jointly with the Colorado Attorney General's Medicaid Fraud Control Unit, the Program Integrity section will examine the State's experience, as well as that of other states, to determine which providers or categories of providers should be required to re-enroll more frequently. The Department will re-enroll approximately one-tenth of the providers every year, and will verify provider information including medical credentials, ownership in an enrolled entity, and licensure status.

  The estimated cost of increasing the frequency of provider re-enrollments, including printing and mailing applications and all related correspondence, as well as contractor costs for employees to process applications, is estimated to be $80,550 in FY 08-09. These are on-going costs, as 10% of providers will be re-enrolled every year.

[2] Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments, Highlights of GAO-04-707, a report to the Chairman, Committee on Finance, U.S. Senate, July 2004, page 14.

- As part of the reenrollment process, the providers identified as high-risk by the Program Integrity section will also be required to undergo a criminal background check and tender a surety bond, at the discretion of the Department. Current state statute (25.5-1-303(3) (f), C.R.S. (2007)) gives the Medical Services Board authority to adopt rules governing the "requirements, obligations, and rights of providers". The Department assumes that such background checks and surety bonds should be considered to be requirements of providers, and are therefore subject to the Medical Services Board's rulemaking authority. It is assumed that only Medical Services Board Rule changes are required to grant the Department authority to determine which provider types will be subject to criminal background checks and surety bonds. Over time, the types of providers posing the highest risk may change, and the Department should be given the flexibility to modify its designation of provider categories over time to reflect changing conditions within the program.

  The Department assumes that the cost of performing background checks on medical personnel is $50 per check. The estimated annual cost of performing background checks on providers identified as high-risk is $169,450. In addition, the Medicaid Management Information System will need to be modified to allow the results of the background checks to be added to the existing database of provider information. The development cost is estimated to be $50,400 in FY 08-09, and is a one-time cost.

  The Department also assumes that 25% of the providers required to re-enroll annually (10% of the total Provider population) will appeal the Department's new requirement to re-enroll, or the Department's decision regarding the provider's eligibility to participate in the program. This will increase the Department's Legal Services and Third Party Recovery Legal Services and Administrative Law Judge Services expenditures. Currently, approximately 85% of the Department's Legal Services and Third Party Recovery Legal Services and Administrative Law Judge Services are related to provider issues and appeals. The annual estimated costs for increased provider appeals are $19,415 for Legal Services and Third Party Recovery Legal Services and $9,631 for Administrative Law Judge Services.

- The Department will pilot on-site inspections of existing and new provider applicants. Such visits help validate a provider's existence and generate information on its service capacity. The inspections will be conducted for providers identified as high-risk, and may include pharmacies, physicians, billing agents, nurses, and other types of providers. In the first phase, a random sample of high-risk providers currently enrolled in Colorado's Medicaid program will be inspected, with new provider applicants to be added later. In order to conduct on-site inspections of high-risk applicants' facilities, inventories, and vehicles, the Department assumes that it would require 4.6 FTE Program Integrity Nurse Reviewers (General Professional V) in FY 08-09, equivalent to 5.0 FTE annualized in FY 09-10. The Department estimates that these employees will conduct 220 one day on-site reviews at an estimated mileage cost of $40 per day and 60 two night on-site reviews per year at an average estimated total cost of $200 per day for mileage, per diems, hotels and incidentals. The total estimated FY 08-09 cost for the described 4.6 FTE Program Integrity Nurse Reviewers, including the projected travel costs is $383,605.

  In addition to the Nurse Reviewers described above, the Department is requesting 1.0 FTE Program Integrity Nurse Reviewer (General Professional IV) to enhance the Department's current Program Integrity capacity. Because of the Department's subject matter expertise, the U.S. Attorney's office is requesting that Program Integrity staff assist with investigations and case preparations. In addition to participating in federal prosecutions, this position would review and monitor podiatry, chiropractic, occupational therapy, and physical therapy provider types, and perform preliminary investigations of referred cases to determine if full investigations were warranted. Such referred cases will come from the new on-site Nurse Reviewers described above, as well as existing Program Integrity staff. The total estimated FY 08-09 cost of this 0.9 FTE Program Integrity Nurse Reviewer, equivalent to 1.0 FTE annualized is $61,187.

Fraud Detection Technology

Although the vast majority of the healthcare providers who care for Medicaid patients are honest and dedicated, numerous studies suggest that between 5 and 13 percent of funds paid to Medicaid providers have been paid in error nationwide (per Public Works research). If Colorado were to experience the same level of erroneous payments it would translate to between $150 and $390 million in state and federal funds that were spent inappropriately.

Every state has a Surveillance Utilization Review Subsystem which profiles providers to identify suspicious provider claims activity after claims have been made. The Surveillance Utilization Review Subsystem measures a provider's claims information against all other providers who reported themselves to be of the same specialty and type. The Surveillance Utilization Review Subsystem uses "edits" and "audits" to identify claims requiring further review, and the state's claims contractor, Affiliated Computer Systems, runs a monthly report on providers whose claims must be reviewed. Edits include computer programming that prevents payment of inconsistent claims, such as a hysterectomy for a male.

Unfortunately, once a payment has been made to a provider committing fraud, recovering the money can be extremely difficult. Several states including Kansas, Florida, North Carolina, Texas, and Illinois, use advanced Medicaid fraud detection software to prevent the payment of suspicious claims. Per Public Works research, in the first half of 2007, Texas recovered more than $200 million in erroneous or fraudulent billings using its arsenal of fraud detection activities including fraud detection software.

Such fraud detection software utilizes neural network and learning technology to detect fraud, abuse or waste in the Medicaid Program. It is able to support functions such as compliance monitoring, provider referrals, and utilization review. In addition, the technology will support the Department's Program Integrity section by providing additional research on potential fraud and abuse; receiving and accessing licensing board data to compare with provider data; looking for known abusive or fraudulent practices using target queries on procedure or diagnosis codes, and tracking the progress of

individual cases, including case hours, investigative cost and travel expenses related to the Medicaid program.

Per Public Works, the estimated cost of such fraud detection technology is $1,000,000 in the first year for the software, which will receive a 90% federal match. In subsequent years, the cost of the technology maintenance is estimated to be $250,000, which will receive a 75% federal match.

The Department recommends that all costs regarding provider re-enrollments and fraud detection technology be appropriated to a new line item in the Department's Executive Director's Office long bill group, to be titled Enhanced Fraud Detection Contracting.

Savings

Strengthening provider re-enrollment and using enhanced fraud detection technology is expected to result in savings. By enhancing the arsenal of fraud detection activities, including additional staff and technological resources, the Department expects to see an increase in the amount of erroneous payments to providers that are avoided or recovered.

Public Works estimates assume that 5% of all Medicaid payments are made in error, and further that 20% of these payments are recoverable or avoidable. This translates to approximately $24,800,000 in total recoverable payments. The Department recovered approximately $8,500,000 in FY 06-07, or an estimated 7% of the assumed 5% of erroneous payments. Public Works estimates assume that the Department will recover 10% in the first year, increasing to 20% by the fourth year. Thus, the total additional savings assumed to be achieved by increasing fraud detection activities is approximately $3,900,000 in the first year, increasing to $16,300,000 in the fourth year. These are saving's to the Department's Medical Services Premiums line item.

Consequences if Not Funded:

Without additional funding, the Department's Program Integrity section would not have the resources to implement strengthening provider enrollment as described above, and would not be able to purchase advanced fraud detection technology. The Department

would continue to recover fraudulent or erroneous payments at the current rate, and would forego all estimated savings from implementing the changes outlined.

Calculations for Request:

Table 1: Summary of Request FY 08-09				
	Total Funds	**General Fund**	**Federal Funds**	**FTE**
Total Request (Column 8)	($2,100,762)	($1,462,981)	($637,781)	5.5
(1) Executive Director's Office, Personal Services	377,611	188,805	188,806	5.5
(1) Executive Director's Office, SB 04-257 Amortization Equalization Disbursement	5,413	2,706	2,707	0.0
(1) Executive Director's Office, Supplemental Amortization Equalization Disbursement (SB 06-235)	2,538	1,269	1,269	0.0
(1) Executive Director's Office, Operating Expenses	59,230	29,615	29,615	0.0
(1) Executive Director's Office, Legal Services and Third Party Recovery Legal Services	19,415	9,708	9,707	0.0
(1) Executive Director's Office, Administrative Law Judge Services	9,631	4,816	4,815	0.0
(1) Executive Director's Office, Medicaid Management Information System Contract	50,400	12,600	37,800	0.0
(1) Executive Director's Office, Enhanced Fraud Detection Contracting (new line item)	1,250,000	225,000	1,025,000	0.0
(2) Medical Services Premiums	(3,875,000)	(1,937,500)	(1,937,500)	0.0

Table 1.1: Summary of Request FY 09-10				
	Total Funds	**General Fund**	**Federal Funds**	**FTE**
Total Request (Column 10)	($5,360,226)	($2,742,612)	($2,617,614)	6.0
(1) Executive Director's Office, Personal Services	$414,476	$207,238	$207,238	6.0
(1) Executive Director's Office, SB 04-257 Amortization Equalization Disbursement	$5,906	$2,953	$2,953	0.0
(1) Executive Director's Office, Supplemental Amortization Equalization Disbursement (SB 06-235)	$1,846	$923	$923	0.0
(1) Executive Director's Office, Operating Expenses	$38,500	$19,250	$19,250	0.0
(1) Executive Director's Office, Legal Services and Third Party Recovery Legal Services	$19,415	$9,708	$9,707	0.0
(1) Executive Director's Office, Administrative Law Judge Services	$9,631	$4,816	$4,815	0.0
(1) Executive Director's Office, Medicaid Management Information System Contract	$0	$0	$0	0.0
(1) Executive Director's Office, Enhanced Fraud Detection Contracting (new line item)	$500,000	$187,500	$312,500	0.0
(2) Medical Services Premiums	($6,350,000)	($3,175,000)	($3,175,000)	0.0

Table 2: FY 08-09 Provider Re-enrollment Cost Calculations			
1	Active Provider Enrollment	50,844	As of 8/31/2007
2	Providers to Apply for Re-enrollment	5,084	Assuming 10% of total providers will be required to re-enroll.
3	Provider Applicants for Re-enrollment	3,389	Assuming 66.7% of selected providers will apply for re-enrollment.
4	Background Checks	**$169,450**	For all providers applying for re-enrollment, assuming $50 per background check. Row 3 * $50.
5	General Fund	$84,725	
6	Federal Funds	$84,725	Assuming that background checks will receive a 50% federal match.
7	Printing, Mailing, and Other Communications Costs	**$80,550**	Assuming annual costs for printing and mailing provider correspondence regarding re-enrollment applications, as well as FTE at the Department's fiscal agent to provide customer service and process provider applications.
8	General Fund	$40,275	Assuming that printing, postage, and other communication costs for fiscal agent processes will receive a 50% federal match.
9	Federal Funds	$40,275	
10	Total Ongoing Estimated Cost for Provider Re-enrollment	**$250,000**	Row 4 + Row 7, This is part of the (1) Executive Director's Office, Enhanced Fraud Detection Contracting (new line item).
11	General Fund	$125,000	Row 5 + Row 8, This is part of the (1) Executive Director's Office, Enhanced Fraud Detection Contracting (new line item).
12	Federal Funds	$125,000	Row 6 + Row 9, This is part of the (1) Executive Director's Office, Enhanced Fraud Detection Contracting (new line item).
13	Medicaid Management Information System Development Costs	**$50,400**	To add background check results to database, assuming 400 hours at $126 per hour. $126 * 400.
14	General Fund	$12,600	Assuming that Medicaid Management Information System development costs will receive a 75% federal match.
15	Federal Funds	$37,800	
16	Legal Services and Third Party Recovery Legal Services	**$19,415**	Assuming 85% of the Department's Legal Services and Third Party Recovery Legal services are related to provider issues and appeals.
17	General Fund	$9,708	Assuming that Legal Services and Third Party Recovery Legal Services costs will receive a 50% federal match.
18	Federal Funds	$9,707	
19	Administrative Law Judge Services	**$9,631**	Assuming 85% of the Administrative Law Judge Services are related to provider issues and appeals.
20	General Fund	$4,816	Assuming that Administrative Law Judge Services costs will receive a 50% federal match.
21	Federal Funds	$4,815	

Table 3: Personal Services and Operating Expenses Calculations							
FTE and Operating Costs						***GRAND TOTAL***	
Fiscal Year(s) of Request		**FY 08-09**	**FY 09-10**	**FY 08-09**	**FY 09-10**	**FY 08-09**	**FY 09-10**
PERSONAL SERVICES	**Title:**	**General Professional IV**		**General Professional V**			
Number of PERSONS / class title		1	1	5	5		
Number of months working in FY 08-09 and FY 09-10		12	12	12	12		
Number months paid in FY 08-09 and FY 09-10*		11	12	11	12		
Calculated FTE per classification		**0.92**	**1.00**	**4.58**	**5.00**	5.50	6.00
Annual base salary		$54,360	$54,360	$62,952	$62,952		
Salary		$49,830	$54,360	$288,530	$314,760	$338,360	$369,120
PERA	**10.15%**	$5,058	$5,518	$29,286	$31,948	$34,344	$37,466
Medicare	**1.45%**	$723	$788	$4,184	$4,564	$4,907	$5,352
Prior Year SAED	**N/A**	$0	$374	$0	$2,164	$0	$2,538
Subtotal Personal Services at Division Level		**$55,611**	**$61,040**	**$322,000**	**$353,436**	**$377,611**	**$414,476**
Subtotal AED at EDO Long Bill Group Level	**1.60%**	**$797**	**$870**	**$4,616**	**$5,036**	**$5,413**	**$5,906**
Subtotal SAED at EDO Long Bill Group Level	**Varies**	**$374**	**$272**	**$2,164**	**$1,574**	**$2,538**	**$1,846**
OPERATING EXPENSES							
Supplies @ $500/$500**	**$500**	$500	$500	$2,500	$2,500	$3,000	$3,000
Computer @ $900/$0	**$900**	$900	$0	$4,500	$0	$5,400	$0
Office Suite Software @ $330/$0	**$330**	$330	$0	$1,650	$0	$1,980	$0
Office Equipment @ $2,225 /$0	**$2,225**	$2,225	$0	$11,125	$0	$13,350	$0
Telephone Base @ $450/$450**	**$450**	$450	$450	$2,250	$2,250	$2,700	$2,700
On-Site Inspection Travel Costs		$0	$0	$32,800	$32,800	$32,800	$32,800
Subtotal Operating Expenses		**$4,405**	**$950**	**$54,825**	**$37,550**	**$59,230**	**$38,500**
GRAND TOTAL ALL COSTS		**$61,187**	**$63,132**	**$383,605**	**$397,596**	**$444,792**	**$460,728**

*Initial year full salary is 11 months to account for Pay Date Shift.

*These costs are incurred every year.

Table 4: Incremental Savings Calculations			
	Item	Amount	Description
1	Medical Services Premiums Appropriation	$2,144,000,000	Per Public Works analysis, approximate FY 07-08 Medical Services Premium appropriation.
2	Department of Human Services- Medicaid Disability Program Appropriation	$331,000,000	Per Public Works analysis, approximate FY 07-08 Department of Human Services appropriations for Medicaid services.
3	Total Medicaid Spending	$2,475,000,000	Row 1 + Row 2.
4	Assumed Spent in Error Annually	($123,750,000)	Assuming that 5% of Medicaid payments are spent in error.
5	Current Recoveries	$8,500,000	Total Funds recoveries in FY 06-07.
6	Estimated Amount to be Recovered in Year 1 (FY 08-09)	($3,875,000)	Assuming that a total of 10% of erroneous payments will be recouped in first year. (Row 4 * 10%) - Row 5.
7	Estimated Amount to be Recovered in Year 2 (FY 09-10)	($6,350,000)	Assuming that a total of 12% of erroneous payments will be recouped in second year. (Row 4 * 12%) - Row 5.
8	Estimated Amount to be Recovered in Year 3 (FY 10-11)	($10,062,500)	Assuming that a total of 15% of erroneous payments will be recouped in third year. (Row 4 * 15%) - Row 5.
9	Estimated Amount to be Recovered in Year 4 (FY 11-12)	($16,250,000)	Assuming that a total of 20% of erroneous payments will be recouped in fourth year. (Row 4 * 20%) - Row 5.
10	Estimated Amount to be Recovered in Year 5 (FY 12-13)	($16,250,000)	Assuming that a total of 20% of erroneous payments will be recouped in fifth year. (Row 4 * 20%) - Row 5.
11	Estimated Savings Over 5-year Period	**($52,787,500)**	Sum of Rows 6 through 10.

Assumptions for Calculations: All assumptions for calculations, as well as formulas, are included in the above tables.

Impact on Other Government Agencies: None.

Cost Benefit Analysis: As shown in the below tables, the Department anticipates that implementing the changes to provider re-enrollment and fraud detection activities in FY 08-09 will result in net savings totaling more than $47,000,000 over the next five years.

Estimated Gross Savings	Total Funds	State Funds	Federal Funds
FY 08-09	($3,875,000)	($1,937,500)	($1,937,500)
FY 09-10	($6,350,000)	($3,175,000)	($3,175,000)
FY 10-11	($10,062,500)	($5,031,250)	($5,031,250)
FY 11-12	($16,250,000)	($8,125,000)	($8,125,000)
FY 12-13	($16,250,000)	($8,125,000)	($8,125,000)

Estimated Costs	Total Funds	State Funds	Federal Funds
FY 08-09	$1,774,238	$474,520	$1,299,718
FY 09-10	$989,774	$432,388	$557,386
FY 10-11	$989,774	$432,388	$557,386
FY 11-12	$989,774	$432,388	$557,386
FY 12-13	$989,774	$432,388	$557,386

Estimated Net Savings	Total Funds	State Funds	Federal Funds
FY 08-09	($2,100,762)	($1,462,980)	($637,782)
FY 09-10	($5,360,226)	($2,742,612)	($2,617,614)
FY 10-11	($9,072,726)	($4,598,862)	($4,473,864)
FY 11-12	($15,260,226)	($7,692,612)	($7,567,614)
FY 12-13	($15,260,226)	($7,692,612)	($7,567,614)

Implementation Schedule:

Task	Month/Year
Internal Research/Planning Period	June 2008
FTE Hired	October 2008
RFP Issued	August 2008
System Modifications Made	October 2008
Rules Written	July 2008
Rules Passed	October 2008
Contract or MOU Awarded/Signed	November 2008
Start-Up Date	December 2008

Statutory and Federal Authority:

42 CFR Part 455: *This part sets forth requirements for a State fraud detection and investigation program, and for disclosure of information on ownership and control…*

25.5-4-301 C.R.S. (2007): *Year Recoveries - overpayments - penalties - interest - adjustments – liens – review or audit procedures… (2) Any overpayment to a provider, including those of personal needs funds made pursuant to section 25.5-6-206, shall be recoverable regardless of whether the overpayment is the result of an error by the state department, a county department of social services, an entity acting on behalf of either department, or by the provider or any agent of the provider as follows…*

Performance Measures:

Actively audit expenditures to decrease fraud and abuse and increase recoveries.

Conduct provider post payment audits to decrease fraud and abuse and increase recoveries.